546-D
GAO/13: HRD-80-72/sum.

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Rising Hospital Costs Can Be Restrained By Regulating Payments And Improving Management

Cost-based retrospective payment for hospital services is inherently inflationary. Yet, because retrospective payment is the prevalent reimbursement method used by third-party payers, both government and private, most hospital payments today are based on costs. Since this system guarantees hospitals the recovery of virtually all reasonable costs incurred, hospitals nationwide have not adopted, to the extent possible, effective and easily implemented management techniques to restrain cost increases.

Some States that have abandoned the practice of paying hospitals based on costs and adopted hospital rate regulation programs have been effective in restraining rising hospital costs. Hospital rate regulation offers promise as a means of restraining future cost increases.

The Congress should amend the Social Security Act to allow the Health Care Financing Administration to broaden Medicare participation in hospital rate regulation programs which contain stronger incentives for improved hospital management.

COMPLETED

ORIGINAL

HRD-80-72
SEPTEMBER 19 1980

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

RISING HOSPITAL COSTS CAN BE RESTRAINED BY REGULATING PAYMENTS AND IMPROVING MANAGEMENT

D I G E S T

Rising health care costs have been and continue to be one of the most serious problems confronting the Nation. Between 1950 and 1978, health care expenditures increased from $12 billion to $192 billion--an increase of 1,500 percent. The percentage of the gross national product spent on health care has more than doubled in the 28 years, from 4.2 percent in 1950 to 9.1 percent in 1978.

Hospital costs, which increased at an average annual rate of 15 percent from 1970 to 1978, account for by far the largest portion of total health care expenditures. In 1950 hospital costs accounted for about 31 percent of total health care expenditures. In 1978 they accounted for nearly 40 percent of the total.

Hospital costs have particularly affected the Medicare program. More than 70 percent of Medicare's total outlays have been for hospital costs. Of the $25.9 billion spent by the Medicare program in 1978, $18.3 billion (71 percent) was for hospital services. Medicare spent only $3.6 billion for hospital care in 1968.

The factors that have contributed to this rapid growth are numerous, complex, and interrelated. Among them are general economic inflation, the manner in which hospital services are paid for, and increased building and equipment costs stimulated, in part, by advancing medical technology and patient demand for hospital care.

The existing cost-based, retrospective hospital reimbursement system acts to discourage hospitals from improving internal efficiency, using services more diligently, or eliminating duplicative services in a locale. Under the cost-based reimbursement system, hospitals are paid by third-party payers on the basis of the reasonable costs (as determined by the payer) incurred in delivering patient care. These costs are determined, in accordance with established cost principles and government and insurance regulations, after the care has been provided. (See p. 15.)

Numerous Federal programs have directly or indirectly attempted to contain the rise in hospital costs. Their effectiveness has been at best questionable, as evidenced by the continued rise in hospital expenditures. Essentially, Federal programs have been directed toward:

--Limiting hospital payment increases through the Economic Stabilization Program and the Medicare program.

--Reducing hospital utilization through the Professional Standards Review Organization program.

--Controlling expansion of hospital plant and equipment through the Health Planning and Resources Development Act.

--Supporting research and experiments in alternative methods of hospital reimbursements.

STATE REGULATORY PROGRAMS HAVE BEEN SUCCESSFUL

In recent years, 26 States have departed from the traditional reasonable cost method of paying for hospital services

and instead have adopted various prospective ratesetting programs under which payments are based on rates determined before the services are provided. These programs are designed to help control rising hospital costs by providing for an external authority to regulate the prices that hospitals may charge and/or that third parties must pay for specified services.

States with such programs were more successful in controlling the growth rate in expenditures per case during 1975-77. During this 3-year period, the annual increase in expenditures per case for all community hospitals averaged 14.9 percent. In States without a prospective ratesetting program, the growth rate averaged 17.9 percent, while States with prospective ratesetting programs averaged 13.9 percent--4 percent less than the States without programs and 1 percent less than the national average. (See p. 34.)

Athough all the reasons some prospective payment programs have successfully controlled hospital cost increases are not readily apparent, there appears to be a relationship between the effectiveness of some programs and the elements essential to an effective ratesetting program identified by the Health Care Financing Administration in 1977. (See p. 37.)

Hospital officials in prospective ratesetting States believe they have been able to contain cost increases primarily as a result of improved hospital budgeting practices. Thus, the presence of an outside review authority forces hospital managers to closely review, and be prepared to justify, planned expenditures. (See p. 45.)

IMPROVED HOSPITAL MANAGEMENT COULD FURTHER REDUCE COSTS

Even though prospective ratesetting programs have restrained hospital expenditures and revenue increases, hospitals generally have not yet adopted cost containing management techniques. Hospitals in States with

prospective payment programs do not use cost containment management practices, such as shared services, energy conservation techniques, and individualized testing procedures, to a significantly greater degree than hospitals in States without a program. Generally, hospital managers nationwide have not implemented cost containment management techniques to the extent possible, even though such techniques can restrain hospital cost increases, according to health care authorities. (See p. 45.)

The Department of Health and Human Services' (HHS') 1/ Health Care Financing Administration has made numerous grants to State health planning and development agencies to demonstrate the effectiveness of ratesetting as a means of controlling health care cost increases. However, the Health Care Financing Administration has limited authority under Medicare to participate in prospective ratesetting programs. (See p. 42.)

RECOMMENDATION TO THE CONGRESS

The Congress should amend the Social Security Act to permit the full participation of the Health Care Financing Administration's Medicare program in existing prospective ratesetting programs.

RECOMMENDATIONS TO THE SECRETARY OF HHS

If the Congress amends the Social Security Act to expand the Health Care Financing Administration's authority for Medicare participation in prospective ratesetting programs, the Secretary should increase the number of programs in which the Health Care Financing Administration is actively

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1/On May 4, 1980, a separate Department of Education commenced operating. The part of the Department of Health, Education, and Welfare responsible for the activities discussed in this report became the Department of Health and Human Services.

participating by making Medicare and permitting Medicaid payments based on program determined rates.

In view of the opportunity to help contain hospital cost increases, the Secretary should promote and encourage the greater use of cost containment management techniques.

In addition, the Secretary should monitor the impact of prospective ratesetting programs on hospital cost increases and periodically report the results to the Congress.

COMMENTS OF HHS, STATE PROSPECTIVE RATESETTING AGENCIES, HOSPITAL ASSOCIATIONS, AND HOSPITALS

Draft copies of this report were provided for comment to HHS, nine State agencies and hospital associations, the American Hospital Association, the Blue Cross/Blue Shield Association, and hospitals included in GAO's review. Their responses are included as appendixes and are discussed in chapter 5.

HHS (see app. XIV) did not fully endorse GAO's recommendation to expand its participation in prospective ratesetting programs should the Congress amend the Social Security Act to permit such participation. HHS said it was waiting for the results of a study of nine prospective ratesetting programs. Because this study will not be completed before late 1982 and because sufficent data are now available, GAO believes HHS should not wait. HHS generally concurred in GAO's other recommendations.

None of the seven State prospective ratesetting agencies (see apps. XVII to XXIII) took exception with the major issues discussed in the report. The four agencies that commented agreed with GAO's recommendation that Medicare should be allowed to pay hospital rates established by ratesetting agencies.

The American Hospital Association (see app. XV) expressed concern about the impact of prospective ratesetting programs on the quality of health care provided by hospitals and the fiscal viability of individual hospitals. GAO is not aware of documentation indicating that quality of care is being adversely affected by prospective ratesetting programs. The financial status of hospitals can be affected by the ratesetting programs. However, other factors, such as poor management and low utilization rates, can have equal or greater impact. The HHS study is looking at both issues.

State hospital associations (see apps. XXIV to XXIX) indicated many of of the same concerns as AHA. One commented that reducing hospital use is the only long-range basis for reducing hospital costs. GAO agrees but believes that, until effective means can be found to reduce hospital utilization, improving hospital management appears to be an important avenue for restraining cost increases. Other State associations said that the voluntary effort is the most efficient and effective way to restrain hospital cost increases. Three State associations endorsed GAO's recommendation to the Congress.

Blue Cross/Blue Shield (see app. XVI) also agreed that the Congress should permit Medicare participation in prospective ratesetting programs. The Association, however, took exception to GAO's conclusion that mandatory ratesetting programs have been the most effective in restraining hospital cost increases, citing the success of some voluntary programs. Though GAO continues to believe that mandatory programs offer the greatest potential for restraining increases, Medicare participation should not be limited to mandatory programs.

Contents

		Page
DIGEST		i
CHAPTER		
1	THE RISE IN HOSPITAL COSTS AND ITS CAUSES	1
	Number, type, and size of community hospitals	2
	Community hospital costs	4
	Impact of increased hospital costs on Medicare and Medicaid program costs	6
	Factors contributing to the increase in community hospital costs	7
	General inflation	9
	Increased hospital use	9
	Increased building and equipment costs	14
	Higher personnel costs	14
	Cost-based, retrospective payment systems	15
	National voluntary effort to contain hospital cost increases	16
	Objectives, scope, and methodology	17
2	FEDERAL EFFORTS TO RESTRAIN INCREASING HOSPITAL COSTS	18
	ESP	18
	Hospital payment limits under Medicare	19
	PSROs	19
	Health Planning and Resources Development Act	20
	Federal support of alternative methods of hospital reimbursement	21
	Canadian hospital services program	24
3	SOME PROSPECTIVE RATESETTING PROGRAMS HELP CONTAIN HOSPITAL COST INCREASES	28
	Hospital payment methods	29
	Existing prospective ratesetting programs	29
	Program types	29
	Rate review and approval techniques	32
	Illustrations of program procedures	33

CHAPTER		Page
	Impact of prospective ratesetting programs on hospital cost increases	34
	Essential program elements	37
	An example of reducing surplus beds	40
	HCFA's participation in prospective ratesetting programs	42
4	IMPROVED MANAGEMENT COULD SIGNIFICANTLY AFFECT HOSPITAL COSTS	45
	Rate review programs have affected hospital operations	45
	Hospital managers have improved budgeting techniques and become more cost conscious because of rate review programs	46
	Other effects of hospital rate regulation	47
	Management techniques that can restrain cost increases are not being used to the extent possible	48
	Shared services and equipment programs	48
	Energy conservation techniques	53
	Preadmission patient testing	55
	Generic drugs and drug formularies	56
	Admission scheduling programs	57
	Nurse staffing systems	59
	Routine admission tests	61
5	CONCLUSIONS; RECOMMENDATIONS; AND COMMENTS BY HHS, STATE PROSPECTIVE RATESETTING AGENCIES, HOSPITAL ASSOCIATIONS, AND HOSPITALS	63
	Conclusions	63
	Recommendation to the Congress	65
	Recommendations to the Secretary of HHS	65
	Comments of HHS, State prospective ratesetting agencies, hospital associations, and hospitals	65
	HHS	65
	State prospective ratesetting agencies	67
	AHA	69

CHAPTER		Page
	State hospital associations	72
	Blue Cross/Blue Shield Association	74
	Hospitals	77
6	OBJECTIVES, SCOPE, AND METHODOLOGY	78
APPENDIX		
I	Information on hospital questionnaire	80
II	Results of questionnaire to health care authorities	92
III	Status of State prospective ratesetting programs	98
IV	Arizona Rate Review Program	101
V	Connecticut Prospective Reimbursement Program	105
VI	Florida Prospective Charge Payment Program	109
VII	Indiana Hospital Rate Review Process	112
VIII	Maryland Health Services Cost Review Commission	115
IX	Massachusetts Ratesetting System	120
X	New Jersey Prospective Reimbursement Program	126
XI	Virginia Hospital Rate Review Program	130
XII	Washington Prospective Reimbursement Program	132
XIII	British Columbia Hospital Program	139
XIV	Letter dated May 16, 1980, from the Department of Health and Human Services	145

		Page
APPENDIX		
XV	Letter dated May 2, 1980, from the American Hospital Association	148
XVI	Letter dated May 29, 1980, from the Blue Cross Association and Blue Shield Association	156
XVII	Letter dated April 10, 1980, from the Connecticut Commission on Hospitals and Health Care	161
XVIII	Letter dated May 20, 1980, from Blue Cross and Blue Shield of Florida	162
XIX	Letter dated April 3, 1980, from Blue Cross/ Blue Shield of Indiana	164
XX	Letter dated March 13, 1980, from the Maryland Health Services Cost Review Commission	167
XXI	Letter dated April 8, 1980, from the New Jersey Department of Health	169
XXII	Letter dated March 11, 1980, from the Virginia Hospital Rate Review Program	172
XXIII	Letter dated April 30, 1980, from the Washington State Hospital Commission	173
XXIV	Letter dated April 30, 1980, from the Arizona Hospital Association	180
XXV	Letter dated March 31, 1980, from the Connecticut Hospital Association	184
XXVI	Letter dated April 2, 1980, from the Florida Hospital Association, Inc.	186
XXVII	Letter dated April 17, 1980, from the Massachusetts Hospital Association	188

		Page
APPENDIX		
XXVIII	Letter dated April 2, 1980, from the New Jersey Hospital Association	193
XXIX	Letter dated May 14, 1980, from the Virginia Hospital Association	204
XXX	Letter dated April 1, 1980, from the Chesapeake General Hospital	206
XXXI	Letter dated March 25, 1980, from the Greater Southeast Community Hospital	209
XXXII	Letter dated March 27, 1980, from the Greenwich Hospital Association	210

ABBREVIATIONS

AHA	American Hospital Association
ESP	Economic Stabilization Program
GAO	General Accounting Office
GNP	gross national product
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HSA	health systems agency
PSRO	Professional Standards Review Organization
SHPDA	State health planning and development agency